

New Evidence on Medicaid and the ACA:

Lessons from Early Expansion States

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Outline

- Background on the 2014 Medicaid expansion and the ACA's early expansion option
- Overview of two projects
 - Interviews with Medicaid Directors on their experiences and lessons learned from implementation
 - Enrollment and coverage impacts of the expansions
- Results
- Discussion & Implications

Medicaid and the Affordable Care Act

- ACA expanded Medicaid in January 2014, using 100% federal dollars:
 - Increases eligibility to all U.S. citizens and qualifying residents with family incomes \leq 138% of Federal Poverty Level (FPL)
 - Supreme Court ruling made this a state option
 - 26 states so far have opted to expand
- But states were offered the chance to do so earlier, at their discretion

Early Expansions

- The ACA gave states the choice to expand to low-income childless adults before 2014, at their traditional match rate of 50-75% (varies by state)
- Some states also have gotten approval for special demonstration programs, or 1115 waivers, to cover childless adults
- We studied 6 states expanding Medicaid to childless adults since 2010

Early Expansions



2010:

- Connecticut, 56% FPL
- D.C., 200% FPL

2011:

- New Jersey, 23% FPL
- Minnesota, 75% FPL
- Washington, 133% FPL
- California, 200% FPL
(varied by county)

Research Questions

- What lessons about implementation might be useful for other states planning or still considering 2014 expansions?
- What were the coverage impacts of the expansions?
 - How fast did enrollment occur?
 - Who signed up, and who didn't?

Study Design

- Mixed Methods Analysis
- *Part I:* Qualitative semi-structured interviews with state Medicaid officials about implementation challenges, strategies, and lessons for other states
- *Part II:* Econometric analysis of enrollment patterns among newly-eligible adults in expansion states versus similar adults in non-expanding states

Part I: Qualitative Interviews

- We interviewed 11 high-ranking Medicaid officials (Medicaid directors or their supervisors, plus key policy deputies) in all 6 early expander states
- Interviews explored enrollment outreach, stakeholder involvement, impact on beneficiaries, implementation challenges, and lessons for 2014

Interviews: Key Findings

- All 6 states were partially or fully replacing state/locally-funded insurance programs for the poor
- 2 states in fact did not enroll any new adults, only transferring previous enrollees from state programs
- Medicaid generally provided more generous coverage, especially for mental health, medical transportation, and expanded provider networks

Interviews: Key Findings

- All 6 states were partially or fully replacing state/locally-funded insurance programs for the poor
- 2 states in fact did not enroll any new adults, only transferring previous enrollees from state programs
- Medicaid generally provided more generous coverage, especially for mental health, medical transportation, and expanded provider networks
- Approximately half of 2014 expander states are in a similar situation, building off prior programs

Predictions are Challenging

- Despite previous experience with this population, enrollment and cost projections were far off in several states
 - One state had twice as many enrollees in Year 1 as expected
 - Two states underestimated enrollment by 20-40%
 - Another state underestimated per-member per-month costs by 12%, requiring revised MCO contracts

Behavioral Health

- 5 of 6 states were surprised by high behavioral health needs in the expansion population
- Substance abuse was common (>10%), especially in the lowest-income group
- On official explained that the expansion *“highlighted the difficulties in trying to operate a program and get services to people where you have fragmented medical, mental health, and substance abuse delivery systems.”*

Administrative Challenges

- Several states were overwhelmed with applications and inadequate staff
 - Contributed to a lawsuit in one state
 - Another state's transfer process required *“printing out their eligibility information from one system and hand-entering it into another system.”*
- Most felt the early expansions didn't fix the IT issues for 2014

Administrative Challenges

- *“Everybody is trying to either do a new IT build or fix their current IT system so I think that is an issue either way [with or without an early expansion]”*
- *“The work we did to do the early expansion, I think did very little to prepare us for the January 1, 2014 expansion.”*

Politics of Expansion

- These six states were generally quite receptive environments for the expansion and ACA more generally
- Strongest stakeholder support came from hospitals, consumers, and community health centers
- Doctors, insurers, and businesses were 'lukewarm' in support
- Little organized opposition in these states

Politics of Expansion

Medicaid Director:

“In a different setting where you have really deep philosophical divides, economic divides, so forth around some of these approaches, I think that the opportunities for the inevitable bumps in the road to blow up into bigger issues are much greater.”

Politics of Expansion

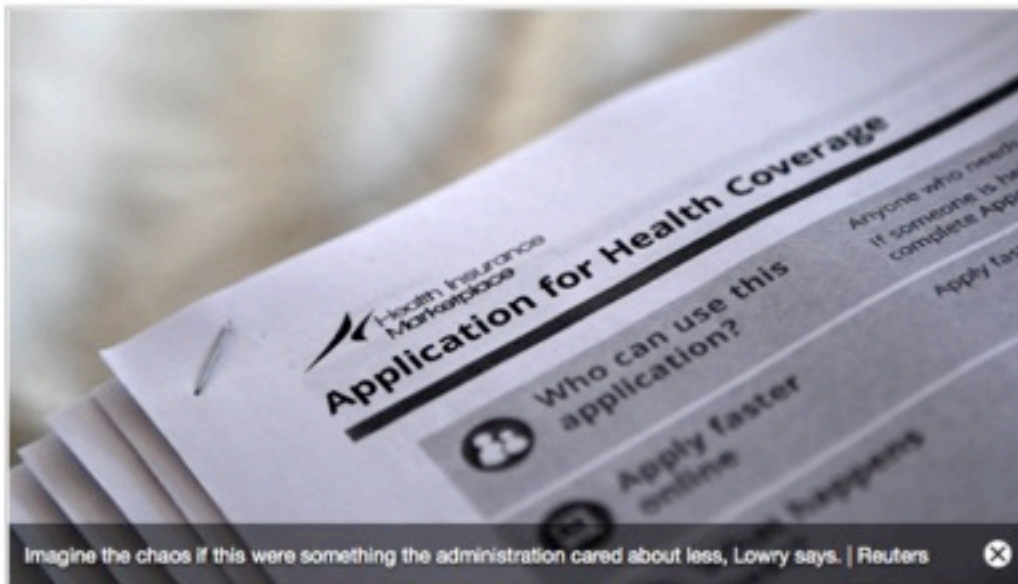
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OPINION COLUMN

Train wreck: The Obamacare rollout

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By RICH LOWRY | 10/10/13 12:33 AM EDT

"I'm not yet ready to be tsar," Nicholas II reportedly said in 1894 when his predecessor died. "I know nothing of the business of ruling."

The tsarina of Obamacare, Secretary of Health and Human Services Kathleen Sebelius, must know how he felt. Given the keys to the kingdom of American health care by the sweeping 2010 law, she appears to have dropped them somewhere and is fumbling to pick them back up.

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Part II: Coverage Impacts

- *But what actually happened to low-income adults in these states?*
- Design: Differences-in-differences analysis
- Sample: Childless adults 19-64, in target income range, in the two earliest state expansions
- Outcomes: Insurance type (Medicaid, uninsured, private coverage)
- Data: American Community Survey, years 2008-2011 (2010 omitted as a washout year)

Methods

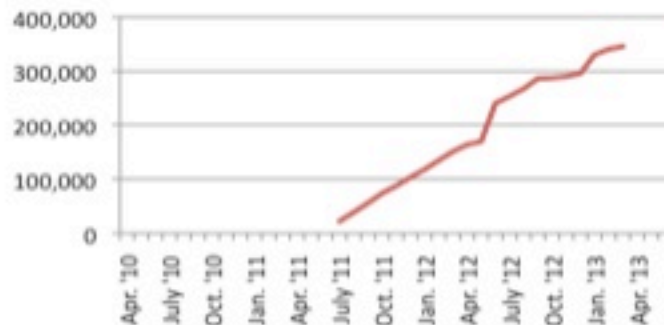
- Control Groups:
 - Connecticut versus Northeast Census Region
 - D.C. versus Virginia
- Linear probability models
 - State-clustered standard errors for CT
 - ACS replicate weights for DC, given only 2 clusters
- Multivariate adjustment for age, race, gender, marital status, income, employment, and citizenship
- Subgroup analyses by health status, and factors above

But first – a word on ramp-up

District of Columbia



California*



Notes: From state administrative enrollment counts, excluding individuals transferring from pre-existing programs.

*CA only included counties that expanded starting in 2011.

Connecticut



Minnesota



Results

State & Population	Medicaid Change	Uninsured Change	Private HI Change
<u>DC</u> : Eligible Childless Adults	3.7%*	-2.8%	-0.1%
--with health-related limitations	6.4%	-3.7%	3.5%
--Income < 138% FPL	3.1%	-1.1%	-2.0%
--Income 138-200% FPL	8.2%**	-7.1%	4.7%
<u>Connecticut</u> : Eligible Childless Adults	4.9%***	-2.8%**	-2.0%***
--with health-related limitations	14.4%***	-11.2%***	-1.7%***
--Age 19-35	5.5%***	-0.9%	-5.6%***

Notes: Changes are differences-in-differences estimates in **percentage-points**, adjusted for sex, race, income, marital status, employment, and citizenship. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Results: Overall Take-Up

State & Population	Medicaid Change	Uninsured Change	Private HI Change
DC: Eligible Childless Adults	3.7%*	-2.8%	-0.1%
--with health-related limitations	6.4%	-3.7%	3.5%
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Results: Health Status

State & Population	Medicaid Change	Uninsured Change	Private HI Change
<u>DC</u> : Eligible Childless Adults	3.7%*	-2.8%	-0.1%
--with health-related limitations	6.4%	-3.7%	3.5%
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Results: Crowd-Out

State & Population	Medicaid Change	Uninsured Change	Private HI Change
<u>DC: Eligible Childless Adults</u>	3.7%*	-2.8%	-0.1%
--with health-related limitations	6.4%	-3.7%	3.5%
--Income < 138% FPL	3.1%	-1.1%	-2.0%
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More Results

- Spillover effects on previously-eligible low-income parents were present in Connecticut (+2.7 percentage-point change in Medicaid, $p < 0.01$), but not in DC
- Sensitivity analyses adjusting for state unemployment rate, excluding non-citizens, limiting analysis to urban areas in Virginia (vs. DC) produced similar key results
- Statistical significance of the increase in Medicaid for DC childless adults was inconsistent across models

Discussion

- Enrollment based on monthly administrative totals was gradual, still rising 3 years into the expansions.
- Coverage gains for childless adults were concentrated among those with health-related limitations, implying potentially higher up-front costs but also greater need
- Private insurance crowd-out in Connecticut was moderate (30-40%), comparable to prior studies, but quite heterogeneous:
 - Crowd-out was very low among sicker adults
 - Crowd-out was nearly 100% among young adults, consistent with what state officials told us they were worried about
 - An old debate: is this good or bad?

Discussion (2)

- Spillover effects were detectable in Connecticut –
 - A “welcome mat effect” that will improve access for low-income parents...

OR

- The “woodwork effect” that will be costly to states in 2014, due to lower federal match rate
- No detectable spillover in DC, where adult take-up rates were already the highest in the U.S.

Sources: Kenney et al 2012, Sommers & Epstein 2010

Limitations

- Early expanders were not typical states:
 - More liberal, more supportive of ACA in general
 - Building off a pre-existing program is not the same as an expansion from scratch
- Officials' subjective views may not match the reality, and miss out on other perspectives
- Differences-in-differences analyses limited to just one year of post-expansion data, and no perfect comparator for D.C.

Conclusions

- Reasons for cautious optimism in terms of enrollment for 2014
- Demand is there, especially among those in worse health
- It likely will take time to reach saturation
- There will likely be some crowd-out and some spillover effects; the policy implications of these patterns depend on your perspective

Questions?

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